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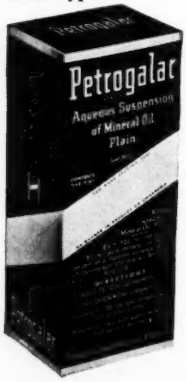

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THE RHODE ISLAND MEDICAL JOURNAL

Volume XXIV DECEMBER, 1941 Number 12

HENRY TURNER OF NEWPORT

A BELATED TRIBUTE TO A PIONEER IN THE FIELD OF CEREBRAL DECOMPRESSION.

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In 1642, Captain William Turner left Dartmouth in Devonshire, England, to settle in Dorchester, Massachusetts, and thus became the founder of a family which contributed notably to the early medical history of our State. Captain Turner was made a freeman of the Colony in the following year. He was a God fearing man to whom religion was more than mere words, for we find that in 1665,[1] "certain persons among whom the prominent ones were Thomas Gouto, Wm. Turner, Edward Drinker, Thos. Osborne, John George etc., finding their views on certain points of Doctrine and Practice, particularly in relation to infant baptism and baptism by sprinkling, to differ essentially from those recognized as Orthodox, among the Puritanical Churches which ruled the Province, withdrew from the Communion of those Churches, and on the 28th. of May established at Charlestown, the Church subsequently known as the First Baptist Church of Boston." That such freedom of thought in religious matters was not looked upon kindly we know from the events leading up to the founding of our own Plantations, and Turner and his companions fared but little better than Roger Williams. They were fined, imprisoned, whipped and banished, but it is pleasing to learn that the Captain, "not being of very flexible material, but rather of the 'sterner stuff' which left so many impressions on the history of those times, declined to sacrifice his convictions." The passage of time, however, must have increased the flexibility of his opponents for he was returned to favor; and in 1676, with a company of a hundred men, he surprised and severely punished a band of Indians at Connecticut Great Falls, now known as Turner's Falls. He was killed by Indians in the same year at Northampton.

Presented at the Annual Meeting of the Rhode Island Medical Society, Newport, May 28, 1941.

Three generations later, the medical succession of the family began with Dr. William Turner who studied medicine in Newport, in the 1720's with Dr. Vigneron in the house at the corner of Farewell and Marlborough Streets. He did not stay in Newport but moved to Newark, New Jersey, where he was a busy and honored practitioner. His son, Peter, studied medicine and returned to Rhode Island, practicing in East Greenwich for many years.

Dr. James Varnum Turner, fourth son of Dr. Peter Turner, was born in East Greenwich in 1789. According to the historian, Bayles,[2] "He acquired the rudiments of his education under the tuition of Master Stephen Franklin, one of the old time pedagogues, who pursued, in its fullest extent, the ancient system of appealing quite as much to the external susceptibilities of his neophytes, as to their intellectual capacity." He married Catherine Ray Greene, who was a descendant of Roger Williams, and whose family included many of the original settlers of Rhode Island. He was one of the charter members of the Rhode Island Medical Society.

Henry Edward Turner was thus in the fourth medical generation of his family, and the best description of his early years which I have been able to find is in his own words, which I quote:[1]

"Henry E. Turner, eldest son of James V. and Catherine Turner, was born at the Govr. Greene 'Homestead', in Warwick June 15th., 1816. Until 1828 the family lived at or near East Greenwich and attended school at the Academy there under Charles H. Alden, Christopher Robinson, Henry Edes, Ebenezer Coleman and others. The next three years, the family being at Portsmouth, he attended the country schools, which were very good, but without Classical teaching; in 1831, he went to Newport, living in the family of his uncle, George

Turner, and attending the school taught by Judge Joslin, in the school house in Church St., formerly John Frazier's, where a previous generation had been trained. This was the extent of his School privileges. At the age of 17, he took up the study of medicine in the office of Wm and J. V. Turner (his uncle and father) and took the degree of M. D. at the University of Pennsylvania in March 1836." In June of that year, he left home for the western country, travelling overland to Jeffersonville, Indiana. He apparently had some idea of settling there, but not finding conditions to his liking, he returned by way of the Mississippi to New Orleans, thence by sea to Boston, and so home.

In September of 1837, he started practice in partnership with his father, an association which lasted until the father's death in 1863. The Newport of those days was a busy seaport, crowded with sloops varying from 25 to 75 tons, and with numerous freight and passenger packets. The fuel used was wood, and large amounts of it were required. Coal was not seen in Newport until 1830, and very little of it was used for many years thereafter. There was a large trade with the Indies, East and West. Travel by land was, according to our standards, very slow; fifty miles a day by stage was considered a good rate of speed. Communication was no faster than the means of transport, until the introduction of the telegraph in 1850. Under these conditions, then, and in the same old house where Dr. Vigneron had instructed his great-grandfather, Henry Turner began a practice which lasted for the next sixty years.

A gentle, kindly man, he soon developed a large general practice, and was very much interested in surgery. From the outset, he was active in public affairs. For nineteen years he was a member of the school committee, and for forty years he was a director of the Redwood Library, eventually becoming its president. He was active and vigorous in politics, serving as Representative in the Legislature for two years. He was a member of the Order of Cincinnati and an honorary member of the Sons of the Revolution.

He was married on July 18, 1844, in the Second Baptist Church, to Ann Eliza Stevens, daughter of Joseph G. and Sarah D. Stevens. They had six children, three of whom were living in 1894, Annie S., Henry E., Jr., and Thomas G. E.

Dr. Turner was greatly interested in historical and genealogical research and wrote several articles on the history of Rhode Island and Newport. He was an active member of the Rhode Island Historical Society from 1874, serving as chairman of its committee on genealogical researches, and was the first resident of Rhode Island to be made an honorary member, in 1897. He was also a member of the Newport Historical Society, and in its archives are preserved several of his manuscript books. These are largely concerned with cemetery records, but one of them contains a careful account of the Turner family from which much of the information given above was obtained. This book is written in a clear, legible hand and shows an interesting but rather needless adherence to custom: the first word of the following page is carefully written at the bottom of each page, as in the printed books of the period, in spite of the fact that the book was apparently bound before the words were written.

His medical activities are shown by his various appointments. He was Port Physician and City Physician from 1853 to 1897, with one very short break, and was Surgeon to the Newport Artillery for twenty-five years. During the Civil War, he was Acting Assistant Surgeon in the Army, serving with the troops at Fort Adams. For many years he was on the Staff of the Newport Hospital and was a member of the Newport Board of Health, and later of the State Board of Health. He became President of the Newport Medical Society, and President and Censor of the Rhode Island Medical Society. On the fiftieth anniversary of his medical graduation he was honored at a banquet by his colleagues and the citizens of Newport, and on the completion of sixty years of practice he was given a loving cup by a similar group of friends.

Here, then, we have the story of a fairly typical doctor of nineteenth century New England. Of good Yankee stock, with a minimum of formal academic and medical education but with a good deal of practical training from older doctors, he was an active, public spirited and beloved practitioner for over sixty years. It is a story which, fortunately for us, has been duplicated many times, and as such it carries no great claim to fame. In a previous publication,[8] however, I have mentioned briefly his observations made on patients suffering from head injuries, and I should like now to consider them in a little more detail.

HENRY EDWARD TURNER
Reproduced from Bayles[2] through the courtesy of the Rhode Island Historical Society.

In the Boston Medical and Surgical Journal of September 25, 1850, Dr. Turner reported a "Case of Fractured Cranium" which he had presented at a quarterly meeting of this Society. His brother Richard had been thrown from a horse, sustaining a[3] "wound on the right side of the head of great extent and frightful appearance. The scalp was lacerated just posteriorly to the temporal fossa, to about the extent of a half dollar; and about two inches posterior to this, a smaller laceration existed. In the anterior of the two wounds the skull was fractured and driven in upon the substance of the brain, so that three fingers might be passed directly down into the brain, an inch or more, without resistance. . . . There was a considerable quantity of brain about the wound, as well as upon the stones where he fell; in fact, the quantity of cerebral matter lost could not (in the whole progress of the case) have been less than an ounce." The patient had been exposed for three or four hours to weather "of the peculiarly penetrating and unpleasant description which characterizes our spring. It is not to be wondered at, therefore (when considered in connection with the extensive loss of blood which must have occurred), that the system was in the lowest state of depression. There was considerable paralysis of the left side, which was very evident upon his attempting to answer questions, which he could do quite pertinently when aroused, although there was considerable stupor, and he was aroused with great effort. Upon examining him, our prognosis was, of course, a fatal one." However, Dr. T. C. Dunn was called and operated upon the patient. He converted the two wounds into one, removed fragments of bone totalling about the size of a dollar, and dressed the wound with lint wet with cold water, changed every ten or fifteen minutes. "On the second morning after the accident, the symptoms became very unfavorable, the convulsive movements set in with renewed force, and the stupor increased; but upon removing the dressings, a quantity of bloody serum and disorganized cerebral matter was removed and instantaneous relief was manifested; and from that time there was a gradual though very slow improvement in the constitutional symptoms, the most serious feature being the remarkable diminution in the rapidity of the pulse, which is almost pathognomonic of serious injuries of the brain, and the removal of which was as gradual as the other evidences of restoration." The patient had a rather stormy recovery. Convulsions were treated by bleeding, and he was given nothing but bread and water for three weeks, after which he was allowed one molasses cookie a day. "After the first few days, a hernia cerebralis occurred, which was treated by pressure made by strips of adhesive plaster drawn over little pieces of sheet lead, and which finally disappeared after about four weeks. At the end of the fifth week, he was removed home, without difficulty, and no unfavorable symptoms afterward occurred to interrupt the cure, which, at the end of the twelfth week, was in all respects perfect, neither his physical or mental condition being at all impaired."

Eleven years later he presented the following account, with an interesting comment on the timelessness of the troubles of committee chairmen.[4] "Having been disappointed in the assistance I had reason to expect from some of my brethren, I have the honor to present, as Committee for the Surgical Department, the following report. . . . On the 19th of September, 1861, I was called in haste to see a man on board a vessel, lying at Long Wharf, in this city, injured in the following manner: A spar had

fallen from aloft, and struck him on the head, producing a fracture of a very peculiar character, viz: a pit, or depression, such as would be occasioned by a man's thumb pressed into dough or putty, with no apparent fracture radiating from it, as might have been expected, but the depressed portion comminuted to an extreme degree.

"I immediately extracted, with forceps, a very large number of fragments of bone, leaving an almost circular hole through the parietal bone, somewhat less than an inch in diameter. Very much to my surprise, I found the dura mater uninjured. . . . I found the man comatose, and he remained in that state about thirty two hours, no recuperative effort being manifested, and no susceptibility to external impressions, when he died. . . .

"I must confess to some disappointment at the entire absence of reaction in the present case, inasmuch as the dura mater was not penetrated, whereas, in my brother's, it was much lacerated, so that the substance of the cerebrum escaped in considerable quantity; and also inasmuch as he received immediate attention and was kept warm, whereas, my brother was exposed for three hours to a chilly, east wind, in April, almost sufficient to cause fatal depression in an uninjured subject. . . . The question very naturally suggests itself, in view of these facts, whether the penetration of the dura mater, and consequent escape of blood, and also the loss of substance, and subsequent protrusion of cerebral matter, in the form of hernia cerebralis, did not, in my brother's case, relieve the brain from pressure, which, in the other case, proved fatal. These reflections did indeed suggest themselves to me in the progress of this case, but I did not feel justified in acting upon them."

A year later, in 1862, he reported a third instance of head injury. The patient was an Irish laborer who had been struck on the head by a billet of wood, in the hands of one of his fellows, twenty-four hours before. Dr. Turner writes:[5] "I found the scalp over and about the parietal protuberance a good deal contused and tumefied, but not much lacerated. He had occasional convulsive movements of the muscles on the left side of the face, which immediately recurred on pressure being made over the seat of injury, which, of course, determined the existence of fracture. As there was no violent reaction, and no coma or other ordinary symptoms of compression (the man being conscious throughout except when under the influence of ether,) I concluded not to operate at that time." Several days later he saw the man again. "As the convulsive movements still persisted, we determined that it was proper to relieve the brain from the compression which evidently existed. Having made a pretty extensive crucial incision, we found a depression of the bone to the depth of half an inch or more, and the depressed portion somewhat comminuted, but not sufficiently so to enable us to remove the fragments with forceps. We therefore applied the trephine above the fracture, and raised the depressed portion with the elevator, and removed the pieces of bone which I exhibit. The dura mater, of course, was perforated; in fact, I could put my thumb down to the first joint into the vacancy in the cerebrum." The patient made a rapid recovery.

"I have been thus particular in giving an account of this case, as it furnishes a pretty good commentary on the doctrine I ventured, with some hesitation, to enunciate a year ago, that, in severe injuries of the head, perforation of the dura mater improves the prospect of relief and final recovery. The case, (my brother's), in which the dura mater was perforated, recovered; in the other, in which it was not, no reaction or consciousness ever occurred. I should not feel justified in opening the dura mater under such circumstances, but I think the question of its propriety worthy of investigation and discussion. I firmly believe that the operation on the present subject would have failed to give relief, had the dura mater remained entire."

Thus, without instruments of precision or laboratory assistance, by careful observation of a few patients over a period of twelve years, and by keen appreciation of the meaning of those observations, Henry Turner was able to establish the basic principle of cerebral decompression—that an opening in the skull does not relieve pressure within it unless it is accompanied by an opening in the dura mater. This accomplishment marks him as one of the great clinical observers and thinkers of American medicine. That he did not carry his idea through into action is a matter of small wonder—the absence of asepsis, and the fear of deliberately induced meningitis were powerful reasons against taking any such radical step. And this does not take away any of the credit which he should re-

ceive for realizing and stating the principle and suggesting its use on patients. But he suffered as many others have suffered from being in advance of the medical thought of his time. I have been unable to find any evidence that his ideas had any effect, or that their importance was realized by any one but himself. It was over thirty-five years later that Victor Horsley,[6] who, in all probability, knew nothing of Turner's observations or even of his existence, made the first deliberate decompression, to be followed by Harvey Cushing[7] in establishing it as an accepted surgical procedure.

We can well be proud of Henry Turner of Newport and his work. May it serve as an inspiration to us, and a reminder that real advances in medicine can still be made by the use of our senses and our sense; by careful observation of a few patients and careful consideration of the facts observed.

Appendix

The Medical Publications of Henry Edward Turner.

1. Case of Fractured Cranium. Read at a Quarterly Meeting of the R. I. Med. Society and communicated for this Journal by order of the Committee on Publications. Boston Medical and Surgical Journal, XLIII, 8:153-154, Sept. 25, 1850.
2. Cases of Tetanus. Read at the Semi-annual Meeting of the R. I. M. S., Dec., 1859. Communications R. I. Med. Soc. 1:77-81, 1877.
3. Supplementary Mammae. Read at the Quarterly Meeting of the R. I. M. S., Oct. 2, 1861. Communications R. I. Med. Soc. 1:172, 1877.
4. Report on Surgery. Read at the Semi-annual Meeting of the R. I. M. S., Dec. 18, 1861. Communications R. I. Med. Soc. 1:185-190, 1877.
5. Surgical Cases. Read at the Semi-annual Meeting of the R. I. M. S., Dec. 17, 1862. Communications R. I. Med. Soc. 1:197-199, 1877.
6. Typhoid Dysentery in Newport. Read at the Annual Meeting of the R. I. M. S., June 1, 1864. Communications R. I. Med. Soc. 1:200-206, 1877.

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1. Turner, H. E.: Manuscript book in the archives of the Newport Historical Society.
2. Bayles, R. M.: History of Newport County, Rhode Island. New York: L. E. Preston and Co., 1888.
3. Turner, H. E.: Case of Fractured Cranium. Boston Medical and Surgical Journal, XLIII, 8, 153-4, September 25, 1850.
4. Turner, H. E.: Report on Surgery. Communications Rhode Island Med. Soc. 1:185-195, 1877.
5. Turner, H. E.: Surgical Cases. Communications Rhode Island Med. Soc. 1:197-199, 1877.
6. Horsley, V.: On the technique of operations on the central nervous system. Brit. Med. Jour. 2:411-423, 1906.
7. Cushing, H.: The establishment of cerebral hernia as a decompressive measure for inaccessible brain tumors; with the description of intermuscular methods of making the bone defect in temporal and occipital regions. Surg., Gynec. and Obst. 1:297-314, 1905.
8. Pickles, W.: Head injuries—observations based on a study of 554 patients. New England Jour. Med. 224, 4:139-142, Jan. 23, 1941.

TORULA MENINGOENCEPHALITIS

REPORT OF A CASE

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The case to be described in this report suffered from a disease sufficiently rare to justify a single report. The material is of particular interest in a study of the diagnosis of intracranial disease.

Torula meningoencephalitis is a uniformly fatal yeast-like infection of the meninges and brain. The diagnosis offers special problems and most of the cases have gone unrecognized to the autopsy table. The sytomatology may closely simulate that of tuberculosis meningitis or of intracranial neoplasm. Stiles and Curtis[1] recently reported that the literature on this disease contains reports of some 95 cases to which they have added a case of their own.

Report of a Case

E.M. The patient was a 59 year old, married, white male adult of New England stock. He had been an industrial engineer by occupation and was considered very capable in his field. His past history was essentially negative except for the fact that he had previously suffered from severe migraine headaches but these had become much milder and rather infrequent during recent years. It was also reported that as a child he had been precipitated into states of delirium whenever he ran a fever.

Toward the end of November 1940 he began to complain that his work was increasingly difficult for him. Early in December of the same year he began to suffer from excruciating right temporal headache. At about this time he was examined very thoroughly by Drs. George L. Shattuck and Harvey B. Sanborn. No significant findings were obtained. On December 21st the patient began to vomit all that he ingested. Seven days later the vomiting ceased as suddenly as it had started. On January 7th, 1941 his sharp right temporal pain, which had remained practically constant since its onset, was replaced by a dull general headache. On

Presented at the meeting of the Rhode Island Society of Neurology and Psychiatry, October, 1940.

The writer expresses his thanks to Drs. George L. Shattuck and Harvey B. Sanborn of Providence for permission to use their findings in this report and to the staff of the Lahey Clinic for permission to use the data obtained while the patient was under their care.

January 9th he began to describe visual hallucinations of a deliriod type. His visions were of little animals running about the room and of strangely colored bizarre shapes. Examination at this time revealed little except that the optic dics appeared as if they might be undergoing early choking. During the next few days he had two attacks of what was described as spells of weakness. In one of these the left hand was observed to twitch. He continued to see little animals playing about his room and on January 13th he was admitted to Butler Hospital for further study.

On admission he seemed somewhat dehydrated and it was rather difficult to hold his attention. He spoke freely of his hallucinations. He was clumsy in skilled acts and the tendon reflexes were markedly reduced. There was questionable choking of both optic discs. Visual fields were negative. His temperature went to 102.4 on the third hospital day, but the following day fell to 98.9 and for the remainder of his stay at Butler Hospital fluctuated between that level and 100.4.

X-ray of the skull done on January 17, 1941, was reported negative.

Laboratory work-up: The urine specimens were essentially negative except for the presence of the slightest possible trace of albumin in three out of four specimens and a few granular casts in one sample. A blood count done on January 14, 1941 showed: RBC 5,030,000; Hemoglobin 100%; WBC 9700; Polymorphoneuclears 80%; Lymphocytes 17%; Monocytes 1%; Eosinophiles 2%.

Blood and spinal fluid tests were negative for syphilis.

Lumbar Punctures: A spinal tap on January 14th gave an initial pressure of 120 but this was probably a spurious reading as considerable fluid had escaped before the manometer could be connected. Laboratory examination of this fluid showed: Cells; 278 Lymphocytes; Pandy positive; Total protein 180; Colloidal gold curve 2223332100.

A repeat tap the following day revealed an initial pressure of 420 mm of water. In this specimen there were 328 lymphocytes and the total protein was 200 mgs.

The third spinal puncture showed an initial pressure of 360. The cell count revealed 230 lymphocytes. A portion of this specimen was cultured in broth but no growth was seen. No tumor cells were seen on a stained smear.

Course in Hospital: The deliriod symptoms continued in spite of correction of the dehydration and scrupulous attention to nutrition. There was also an increasing tendency toward somnolence and toward the end of his stay at Butler Hospital it was almost impossible to keep his attention.

On January 28th he was transferred to the Lahey Clinic with a diagnosis of intracranial neoplasm. From the preliminary studies this clinic concurred in the diagnosis and decided to do a ventriculography to be followed by a craniotomy. The ventriculogram showed both ventricles to be symmetrically dilated. It was assumed that the pathology must be subtentorial and the cerebellar approach was used in the performing the craniotomy. As soon as the meninges were exposed it was seen that they were diseased. The arachnoid was markedly thickened and there were yellowish flecks of exudate lying beneath its surface. A piece of tissue was removed for biopsy and the operative wound closed. The pathological examination of the material removed at operation showed an inflammatory reaction with many giant cells. The spinal fluid was then cultured for M. Tuberculosum and Torula Histolytica. On the 12th post-operative day a growth of Torula was obtained.

A review of the literature revealed nothing in the way of therapy except that *in vitro* acroflavine showed a strong inhibitory action on Torula. Therefore this drug was administered intrathecally. The patient, nevertheless, continued his downhill course and died on the 18th post-operative day, February 16, 1941. The duration of life after the onset of the first definite symptom was two and one-half months. Unfortunately no autopsy was permitted. It was considered however that the diagnosis had been confirmed by the biopsy plus the positive culture.

Summary

A case of Torula Meningoencephalitis is presented. The simulation of brain tumor is most striking. This report will serve as a reminder that in spite of the many recent advances the diagnosis of intracranial pathology still presents many pitfalls.

Reference

1. Torula meningoencephalitis; report of a case; observation of the cerebrospinal fluid. Stiles, W. W. and Curtis, A. N.—J. A. M. A. 116: 1633 (April 12) 1941.

OVARIAN PREGNANCY
CASE REPORT

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Extra-uterine or ectopic pregnancy may be defined as that condition which arises when a fecundated ovum lodges and imbeds itself in any situation outside the cavity of the uterus, nidation proceeding in the aberrant site for a variable period.

There are several well differentiated varieties of this lesion as the ovum is arrested and develops in one or another site, the varieties being marked by differences in physical signs, symptoms, in termination and in results, as well as the varying relactions of the tissues, in which such abnormal implantation occurs, to the presence of trophoplastic activity.

Extra-uterine pregnancy being solely a disease of the childbearing period, its age incidence is necessarily limited. The most frequent age for the development of ectopic gestation then, is the decade between 24 and 33 years, and as most American girls marry in the early twenties, it follows that the majority of these cases occur within the first ten years of married life. This fact is significant, in view of the commonly repeated statement that extra-uterine pregnancy occurs most commonly after a prolonged period of sterility, or at least of unfruitfulness.

An ovum may be arrested anywhere in its passage from the ovary to the uterine cavity, and may imbed in any portion of the genital tract distal to this cavity; hence the several varieties of ectopic gestation are to be considered solely in relation to that portion of the genital tract in which the aberrantly situated ovum imbeds and develops.

This classification is based upon the original point of implantation of the fertilized ovum. Beginning at the uterus, there may be a corneal, interstitial, or apical pregnancy when growth of the implanted ovum proceeds within the thickness of the uterine wall in the tubal lumen; isthmial when the arrest takes place in the constricted isthmus of the tube; ampullar when embryological development goes on in the expanded, trumpet shaped ampulla of the tube; tubo-ovarian when the abnormal site is at the fimbriated extremity of the tube, which in this case is attached to the ovary by preexisting adhesions. Ovarian pregnancy, the rarest of the primary forms, occurs when the ovum is fertilized without having been extruded from the graafian follicle, the development continuing within the cortex of the ovary.

This rare and interesting variety of ectopic gestation has not been reported in sufficient number to formulate any specific cause, histologically demonstrable. It is believed that, after fertilization, the ohagocytic ovum may burrow into another or deeper portion of the ovary.

It has been stated that ovarian is the rarest form of ectopic pregnancy, except perhaps the cervical variety, which is almost unique. Norris in 1909 reported 19 positive cases of ovarian pregnancy in the literature, when all those which did not comply with all the criteria of this form of gestation were excluded. Lockyer has surveyed the literature from 1909 to 1917, and finds during this interval 22 genuine cases, making a total of 42; since 1917 there have been reported three additional cases, making a total of 45 to date.

Certain established conditions must be fulfilled, if the specimen in question is to be regarded as one of proven, primary ovarian gestation:

1) the tube on the affected side must be intact

2) the fetal sac must occupy the position of the ovary

3) it must be connected with the uterus by the utero-ovarian ligament

4) definite ovarian tissue should be found in the sac wall.

Placentation in ovarian pregnancy probably follows the same course as in uterine or tubal pregnancy, except that the greater vascularity of the ovum permits of more complete placental attachment and a consequent more definite blood supply to the ovum. As to the formation of decidua in the ovary, while the question cannot be said to have been absolutely determined, the views of nearly all of those who have recently studied this matter coincide in the belief that in the ovary, as in the tube, no true decidual reaction takes place, but that there

Presented at the one hundred and thirtieth Annual Meeting of the Rhode Island Medical Society, Newport, May 28-29, 1941.

is formed a tissue consisting of fibrin, lutein cells and masses of trophoblast, which may be termed a pseudo-decidua and which is the expression of the reaction of the ovarian tissue to the irritation produced by the erosive action of the trophoblast.

The duration of ovarian pregnancy is in the main longer than that of the tubal variety by reason of the different nature of the tissues enclosing the embryonal sac. The ovary is far more elastic and resilient than the tube, as evidenced by its distention in cases of dermoid cysts. The substance of the ovary is also so much thicker than the tube wall that penetration of the former by chorionic villi is most improbable, while in the latter it is the rule. These facts account for the longer duration of ovarian pregnancy, many of them, indeed, going to term. When rupture of an ovarian pregnancy occurs, it is occasioned in the same way as in tubal pregnancy—the invasion of the cyncytium into blood vessels may cause intracapsular or extracapsular bleeding or the sac may become thinner and no longer able to resist the increasing pressure of the growing ovum. The intraperitoneal bleeding may be very slight, or, as in ruptured tubal pregnancy, severe. In the former instance the process may go on to resolution or undergo inflammatory change, in the latter, a sudden dramatic intraperitoneal and death may ensue.

Ovarian pregnancy presents no feature which permits its diagnosis before rupture of the gestation sac, nor are there any distinctive signs after rupture which serve to differentiate it from other forms of extrauterine pregnancy. Diagnosis is only to be reached, after removal of the specimen, by the most thorough and painstaking microscopic and gross examination.

I should like to report a case of true ovarian pregnancy at this time. Mrs. H. W., a para II, age 33, white female, consulted a local physician October 24, 1940. Her last menstrual period was August 26, 1940, establishing expected confinement June 2, 1941. The pelvic measurements were normal; blood pressure 120/70, weight 152½; urine was normal. Her last confinement was sixteen years ago when she had a forceps delivery of a live male child. Eight years ago she had a cauterization of the cervix for vaginal discharge and low back pain. She has been in good health until the present pregnancy.

On November 26, 1940, the patient again consulted her physician. The blood pressure was 124/60, the weight 151. Bimanual examination was apparently normal except for marked discomfort during pelvic examination. There was a history of a little brown staining during the past week but none was found during the examination. The patient complained of lower abdominal pain, more of a bearing down pressure. There had been some nausea but no vomiting.

On November 29, 1940, I was called to visit the patient at her home and was asked to take over the case because her present physician was leaving the city for postgraduate instruction. At this time the patient complained of some lower abdominal pain with constipation and was advised accordingly. Three days later, on December 2, I was again called to the house and found the patient constipated and vomiting. Immediate hospitalization was advised because of the vomiting.

On admission to the hospital, the temperature was 99.6, the urine normal; the blood count, red blood cells 3,900,000, hemoglobin 70%, leucocytes 8800 with 68% polys. Physical examination disclosed blood pressure 130/80. The abdomen was moderately distended with tenderness in the left lower quadrant. Pelvic examination disclosed a lacerated cervix with a fullness in the cul-de-sac—the fundus could not be made out as to size and position. The patient responded well to simple therapy. She was seen in consultation with her physician who had not as yet left for postgraduate training with the conclusion that she was an apprehensive patient with pressure symptoms. She left the hospital feeling well on December 5, 1940. On December 18 she came to my office feeling well except for some lower abdominal pressure symptoms.

January 6, 1941, I was again called to the home and again found the patient moderately distended with tenderness in the lower abdomen and some vomiting. She was again hospitalized. At this time the temperature was 99.2, red blood cells 3,100,000, hemoglobin 62%, white blood cells 10,800 with 89% polys; the blood pressure was 120/76. Gastric lavage was done and the patient felt much better. Physical examination at this time showed the abdomen moderately distended, tenderness in the lower abdomen, more in the left lower quadrant. Pelvic

examination revealed the fundus to be about four months pregnant; there was marked tenderness in the posterior cul-de-sac with tenderness on motion of the cervix—no discharge or bleeding. It was thought that a small ovarian cyst might have ruptured. The patient became progressively better each day so that on the third day after admission the red blood cells were 3,320,000, hemoglobin 64%, white blood cells 8,000 with 75% polys; sedimentation rate 22 mm. per hour.

On the evening of the third day an enema was given because of the constipation and distention. Approximately thirty minutes later the patient suddenly went into shock and died before any further help could be offered. At this time it was thought that we had been dealing with an abdominal pregnancy which had ruptured.

An autopsy disclosed the following:—The peritoneal cavity contained one and a half liters of blood. A large mass presented itself in the midline with a fetus attached by the cord to the implanted placenta, the fetus having been exruded through a perforation of the mass which was in reality the right ovary. The right tube was plastered on the ovary posteriorly. The uterus itself was not enlarged and was pushed down, together with the left adnexa, into the left pelvic quadrant. The pelvic organs were removed in toto. Final examination revealed an ovarian pregnancy of four and a half months which had ruptured, extruding the fetus into the peritoneal cavity. The placenta was attached entirely to the ovary.

THE NEEDS OF THE CARDIAC CHILD

One type of crippled and handicapped child has been much neglected and, as his disease has inevitably produced isolation, this child has been forgotten. This refers to the rheumatic child with permanent heart damage and to the less common one handicapped by congenital heart disease. This type of patient is called the cardiac child.

How easily, in the early years of practice, the young physician hopelessly shakes his head when he, in making his round of duty, encounters the young girl or boy, often entering the early years of adolescence suffering from rheumatic heart disease, offers a poor prognosis and passes upon his way. Yet how often in the accumulation of years of experience the older physician has watched such children suffer for weeks and months with cardiac pain and distress and then has seen them weather the storm of many years of invalidism, acute illness, contagious disease or other accident to emerge as fairly healthy members of a community and live a happy and profitable life. Those who do not succumb to their heart affliction in the early years of their life should never be given up as hopelessly lost.

Rheumatic fever may rightly be called the scourge of childhood. Of all the patients admitted to the wards of our hospitals the suffering of this group is the keenest, their disease the most protracted and damaging to the heart. Respiratory disease, which so often stimulates a recurrence of the rheumatic infection, takes a large toll of life of these children. In addition, periods of broken heart compensation produce death or irreparable damage to the heart.

Programs for the care of these children are already in operation in some states and it is hoped that, in the near future, Rhode Island may be able to offer help to them.

A tentative program for care of the cardiac child should include:—

1. Hospitalization for the duration of the acute rheumatic and cardiac symptoms. Cost $5 to $6.50 per day.

2. Care in a convalescent hospital until the temperature, blood count and sedimentation rate have become normal. At present the Crawford Allen Hospital and the Lakeside Home will provide such care for these children. Cost $1.50 to $3.50 per day.

3. Home Care. During the convalescent period, if home conditions are suitable, parents should assume responsibility for the patient. Isolation is important because of the detrimental effect of respiratory infection. If the child happens to be a member of a small family with other well managed siblings the child's own home may provide the proper place for after care. If, on the other hand, there are other small children who are poorly managed with resultant confusion in the household, and, particularly if these children are susceptible to respiratory infections, the foster home is advisable. Life in a foster home with a small family is to be preferred if there are many disturbing elements in the child's own home. Isolation of these patients is

important although the experiment in recent years of giving sulfanilamide throughout the winter, to lessen the incidence of colds, has been tried successfully. Occasional white blood counts have been necessary with these children. Cost in foster home $1 to $2 per day.

4. Medical Care. This must be delegated to competent internes and pediatricians. The frequency of their visits should be judged by the physician and the attending nurse and should be under the control of administrative headquarters. A fee should be paid to the physicians for these visits. Further, it may be deemed advisable for a part time technician to make blood counts or sedimentation tests occasionally.

5. Nursing Care. After the child has left the hospital or convalescent home expert nursing care to regulate his life is most essential. Co-operation of the local visiting nursing association, school nurses, and state public health nurses must be secured. The work delegated to these nurses will depend somewhat upon the geographical location of the child. The number and frequency of these nursing visits would naturally be regulated by the severity of the illness.

6. Sociological Care. Each patient should be tutored during the period of convalescence. A paid social worker should make such arrangements with local school authorities, unless the family finances are sufficient to provide for this item.

The social worker should further, in co-operation with nurse and doctor, provide a pleasant home atmosphere for the patient. The child's interest in his own condition should be stimulated; he should be encouraged to bear some responsibility for his future health and he must be taught the dangers of extraneous infection. In some instances clubs have been formed with these children as members; letters have been written from one to the other in their homes, books exchanged and small papers have been published with members contributing articles of interest. Such forms of entertainment shorten the long day and tend to make these little sufferers akin to each other.

Administration of the Program

Such a program as outlined must be conducted with the aid of federal funds, state funds, or those provided by a state-wide subscription canvass.

Under government subsidy the administration should be placed under the department of Crippled Children or under the jurisdiction of the Rhode Island Bureau of Child Health, a subsidiary of the Rhode Island State Health Department. Even though some states have already been able to secure federal grants it is doubtful if, at present, with such enormous expenditures for national defense, funds can be obtained for such a program of constructive health.

Under state aid or even if the program is carried out by public subscription it still might be supervised by one of the above departments. If such a program could be launched by public subscription, when war with its terrific expenses has passed into history, it is more than possible that federal funds might be obtained by co-operation of the U. S. Child Health Bureau which would naturally expect the program to function through state health department channels. One assistant to the head of the department of Crippled Children or the Child Health Bureau would probably be essential. The Rhode Island State Health Department has already had several conferences with representatives of the Federal Child Health Bureau. The Children's Heart Committee has done much constructive work on such a program, with special emphasis on the development of convalescent homes. The Child Health Relations Committee of the Rhode Island Medical Society in co-operation with the American Academy of Pediatrics is devoting much effort to the program.

That there is ample need for a program devoted to the care of the cardiac child in this state there can be no question. Extensive investigations by the heads of the social services of our hospitals have been undertaken. The number of children found requiring both medical and nursing care has been enlightening. With the able assistance of these social workers the program once instituted would probably reveal many cases in isolated districts hitherto not added to the already rather imposing list of those who would benefit from such a program. As with all such medical ventures, their potentialities are not fully appreciated until the program has been well started, when lead after lead always throws light upon the future possibilities of such work. The cardiac child, if he is to lead a life beneficial to himself and the community, needs our care and attention.

HENRY E. UTTER, M.D., *Chairman*
Child Health Relations Committee
Rhode Island Medical Society

THE RHODE ISLAND MEDICAL JOURNAL
Medical Library Building
106 Francis Street, Providence, R. I.

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Midwinter Meeting

A joint meeting of the Rhode Island Medical Society with the Providence Medical Association will be held at the Medical Library Building on the evening of Monday, February 2, 1942.

AMERICAN COLLEGE OF PHYSICIANS

Providence Meeting

Preliminary plans for the New England Sectional Meeting of the American College of Physicians to be held at Providence, R. I., on Wednesday, January 14, 1942, have been announced by Alex M. Burgess, M.D., Rhode Island Governor of the College. In the morning, from 10 until 12, clinical sessions will be held at the Peter's House at Rhode Island Hospital under the supervision of Charles F. Gormly, M.D., general chairman of the local group planning the meeting, and at noon luncheon will be served at the hospital.

The afternoon will be devoted to scientific discussions at the auditorium of the Rhode Island Medical Library, with the presentation of papers by outstanding members of the College in New England from 2 to 5 p. m. The day's program will be concluded with a dinner at the Squantum Club at 6:30 P. M.

The local Committee in charge of the meeting, in addition to Drs. A. M. Burgess and C. F. Gormly, includes Dr. William S. Streker, Dr. Elihu S. Wing, and Dr. John F. Kenney.

THE NATIONAL PHYSICIANS' COMMITTEE

ACCOMPLISHMENT

In October, 1939, the first letters and literature were mailed to physicians from the offices of the National Physicians' Committee. At that time the Wagner National Health Bill was before the Senate sub-committee on Education and Labor; the American Medical Association was awaiting trial in a Federal Court; five officers of the American Medical Association and fourteen physicians of Washington, D. C. were under Federal Grand Jury indictment for criminal conspiracy to restrain trade. A powerful lobby, with professional workers and powerful friends at court, was active at Washington and in state capitals, working for the socialization of medical practice with the benefit of Federal Funds. The proposals were to revolutionize the practice of medicine, placing the distribution of medical care in the hands of laymen or lay groups.

The objects of the National Physicians' Committee are to impress the profession with the importance of the basic issues, to educate the public to an understanding of the executive results of our system of medical practice, and to promote extension of the distribution of efficient medical care. An intensive educational program has been carried on by letters to the profession, distribution of pamphlets, articles in medical magazines and in the press.

Local medical societies have organized many projects for providing medical care for patients in the low income group on a prepayment basis. These efforts have already succeeded in providing better medical care for many thousands of patients who were neglected except for the work of free clinics. Of even greater importance, the medical profession is alive to its responsibility to provide the best possible medical care at the lowest possible cost.

The present emergency has aided the work of the National Physicians' Committee. An individual may trust his minor complaints to an irregular practitioner, a technician or a social worker, but when he has a real pain he wants the best medical attention in a hurry. In the present crisis there is no call for the irregulars but an insistent demand for medical graduates. In the Selective Service alone

many thousand American physicians are performing invaluable service and without remuneration. Of their work General Hershey says, "We have got something far beyond what you can hire at the wages we would expect to pay."

But when this emergency is over the campaign for socialized medicine under lay control may regain its delayed impetus. Then the work of the National Physicians' Committee will again prove its value in preservation of the ideals of American Medicine.

Report on the status of medicine and the operation of the National Physcians' Committee, October 17, 1941.

Medicine and selective service. Lewis B. Hershey, Director of the Selective Service System. The Journal A.M.A., 117: 22, 1894, Nov. 29, 1941.

CIVILIAN DEFENSE

October 27, 1941

Advanced First Aid for Civilian Defense

The U. S. Director of Civilian Defense has urged all communities to spread knowledge of first aid as widely as possible among the people. Competent instructors qualified by the American Red Cross are required for training Civilian Defense workers, employees of industrial plants, business establishments and Government bureaus. For this purpose, physicians should register as instructors with the local Red Cross Chapter and should employ the "Instructor's Outline" for the standard course (20 hours), prepared by the American National Red Cross in collaboration with the Medical Division of the Office of Civilian Defense and published by the American Red Cross. Upon completion of this course, participants will be entitled to receive the First Aid Certificate of the Red Cross and be authorized to wear the appropriate insigne.

The booklet entitled "Advanced First Aid for Civilian Defense," prepared by the American National Red Cross in collaboration with the Medical Division of the Office of Civilian Defense and published by the American Red Cross, is intended for the first aid instruction of the medical and nursing personnel of Emergency Medical Field Units and for the training of Air Raid Wardens and members of other enrolled groups of the Citizen's Defense Corps.

Physicians who are members of Emergency Medical Field Units should familiarize themselves with the first aid methods outlined in this booklet. They should register in the local Red Cross Chapter so that they may serve as instructors to both student and graduate nurses as well as Nurses' Aides and other non-professional members of their Unit and other hospital employees. These 5 two-hour lessons will not provide non-medical Civilian Defense workers with adequate training and experience in the skillful application of first aid procedures. They are intended to supply minimum instruction which must be followed by repeated drilling under competent supervision.

Because of the exacting training requirements for certain enrolled groups of the Citizen's Defense Corps, this 10-hour course, "Advanced First Aid for Civilian Defense," may be interpolated in their instructional curriculum with the understanding that it will be supplemented subsequently by additional first aid training as required for others who have not had previous experience.

Additional copies of "Advanced First Aid for Civilian Defense" are obtainable for free distribution by application to the Regional Director or Regional Medical Officer in your Civilian Defense Region. For copies of the "Instructor's Outline" (20 hour course), applications should be addressed to the local Red Cross Chapter.

GEORGE BAEHR, M.D.,
Chief Medical Officer.

October 29, 1941

Duties of the Local Chief of Emergency Medical Services

In order to expedite the organization of the Emergency Medical Services and provide for their effective administration, it is important that each local Civilian Defense Council appoint without delay a local Chief of Emergency Medical Services. He should be an outstanding medical leader and should be selected in consultation with the State Defense Council, the local Medical Society, and the local Health Officer. To facilitate the integration of all local medical resources into a comprehensive program for civilian protection, the local Chief of Emergency Medical Services should be assisted by a Medical Advisory Council, consisting of the local Health Officer, an experienced

hospital executive, and representatives of the local Medical Society, the local nursing profession, the American Red Cross, and any participating voluntary agencies.

Under the administrative authority of the local Director of Civilian Defense the duties of the local Chief of Emergency Medical Services are:

1. To determine the scope of the activities of all official and voluntary organizations which are to participate in the emergency medical program of civilian defense, to integrate these organizations into the comprehensive local program, and to assist them in expanding their activities to the limit of their resources in personnel and equipment.

2. To assist hospitals in the locality to organize, equip and train Emergency Medical Field Units as outlined in Medical Division Bulletin No. 1, "Emergency Medical Service for Civilian Defense."

3. To inspect and select sites for the establishment of Casualty Stations.

4. To make a spot map of the locality, indicating the locations of hospitals, appropriate sites for Casualty Stations, depots for storage of stretchers, blankets and collapsible cots, and the locations of rescue squads. The map should indicate the number of Emergency Medical Squads in each hospital. Copies of the map should be supplied to Control Centers, Police and Fire Departments, Health Department, local Red Cross Chapter, State Defense Council, Regional Director, Regional Medical Officer and to all cooperating hospitals.

5. To plan and establish adequate transportation service for casualties and medical personnel in consultation with local government departments, American Red Cross and voluntary agencies.

6. To arrange with the local Control Authority for field drills of Emergency Medical Units and Rescue Squads in collaboration with police and fire auxiliaries, disaster relief and canteen services of the American Red Cross, ambulance transport service and other civilian defense units and to supervise such drills.

7. To make an inventory of hospital beds in the locality and of the possibilities for emergency expansion in bed capacity.

8. To assist the authorities charged with preparing plans for evacuation in making an inventory of hospitals, convalescent homes, sanatoria, hotels and other structures within a radius of 50 to 100 miles which might be used as base hospitals to which patients in city institutions could be evacuated.

9. To assist the local Central Volunteer Bureau in establishing courses for volunteers in the field of health, medical care, nursing and related activities.

10. To stimulate recruitment of volunteers for Nurses' Aide courses of the American Red Cross, assist the local Red Cross chapter in establishing Training Centers for Volunteer Nurses' Aides at appropriate hospitals and assist the Red Cross placement bureau in placing Nurses' Aides with hospitals, clinics, health departments and field nursing services after completion of training.

11. To stimulate and guide extension of First Aid training courses as widely as possible among the local population through the American Red Cross and other official and voluntary agencies.

12. To stimulate and guide industrial plants, business establishments and government bureaus in the locality in the training and organization of effective First Aid Detachments among the employees.

13. To collaborate with state and local health departments and through them with the Regional Sanitary Engineer in a comprehensive program for the protection of the community against emergency sanitation hazards.

14. To collaborate with local and State Defense Councils, Office of Civilian Defense, Federal Security Agency, Children's Bureau and other local, State and Federal authorities in the preparation of plans for evacuation, with particular attention to the medical needs of the population under such circumstances.

15. To keep the community and particularly the members of the health and medical professions and the participating official and voluntary organizations informed of the plans and activities of the local Emergency Medical Services.

GEORGE BAEHR, M.D.,
Chief Medical Officer.

December 1, 1941

The national emergency has brought about a shortage of nurses in hospitals, clinics, public health and field nursing agencies. To relieve this situation, which is likely to grow more acute with the expansion of military establishments and of plans for civilian defense, the American National Red Cross and the Office of Civilian Defense have jointly undertaken a project to train volunteer nurses' aides. With such assistance, graduate nurses may extend their services to many more persons. The volunteer aides will work under supervision of a nurse and are being trained for certain non-technical tasks in order that graduate nurses may be released for the highly technical duties they alone are qualified to perform.

The local chief of Emergency Medical Service and the local Office of Civilian Defense in communities where the training program is undertaken have definite responsibilities listed as follows by the national headquarters of the Office of Civilian Defense:

1. To assist the Red Cross and the Civilian Defense Volunteer Office in recruiting and enrolling desirable applicants for training.
2. To assist local chapters to conclude arrangements with appropriate general hospitals to serve as training centers.
3. To assist the Red Cross in organizing and maintaining a placement service so that Volunteer Nurses' Aides may continue to serve and to accumulate experience.
4. To reassign Volunteer Nurses' Aides to emergency duty if the need should arise.

The Red Cross, in collaboration with the Medical Division of the Office of Civilian Defense, has revised its standard course of instruction for Volunteer Nurses' Aides with reference to needs that may develop during the period of the national emergency. The standard course was instituted in July 1940, an outgrowth of volunteer services that have been sponsored by the Red Cross since World War I.

The first half of the course, consisting of lectures and demonstrations, is given in a Red Cross chapter house or some other suitable place. The second half is to be given in a hospital selected by the Red Cross and the Office of Civilian Defense as a training center under strict supervision.

Nurses' aides are to work under supervision of a nurse at all times, never independently, the instructions point out. Moreover, they must agree to serve without remuneration and in time of national peril must be prepared to serve whenever and for as long as period as needed.

Authorized duties for the nurses' aides have been outlined in the Red Cross publication "Chapter Organization and Administration of Red Cross Volunteer Nurses' Aide Corps." These duties are of course subject to approval of individual institutions.

In hospitals they may, among other activities, make beds, take care of personal belongings of patients, take care of rubber goods, clean dressing trays, take care of linen closets, feed helpless patients, take patients to and from treatment rooms, help with admission and discharge of patients and care for ambulatory patients. In dispensaries and clinics the aides may serve as interpreters in foreign languages, interpret clinic rules and instructions to patients, help weigh and measure, undress and dress children, assist in taking physicians' notes, help with inventories, clean and put away instruments and help put rooms in order after clinics.

In community health agencies the aides may perform whatever nursing duties are approved by the organization for which they work, provided these duties are performed under the direct supervision of a nurse.

AMERICAN MEDICAL ASSOCIATION BROADCASTS

Doctors at Work, the dramatized radio program broadcast by the American Medical Association and the National Broadcasting Company will go on the air for its second season beginning December 6, 1941, from 5:30 to 6:00 P. M., Eastern Standard time. The program will be broadcast on WJAR and upwards of seventy-five stations affiliated with the Red Network of the National Broadcasting Company and will be heard from coast to coast.

Doctors at Work, a successful, serialized story broadcast last year dealt with the experiences of a fictitious but typical American boy choosing medicine for his vocation and proceeding to acquire the necessary education and hospital training for the private practice of medicine. Interwoven with the personal story of young Doctor Tom Riggs and

his fiancee, Alice Adams, was the romance of modern medicine and how it benefits the doctor's patients.

The new series of broadcasts will resume where last year's story left off, namely, with the marriage of Tom Riggs and Alice Adams, and the subsequent life of a young doctor and his wife in time of National Emergency in a typical, medium-sized, American City.

The program will be produced under the supervision of the Bureau of Health Education, of the American Medical Association, W. W. Bauer, M.D., Director. Scripts will be by William J. Murphy of the National Broadcasting Company, author of such successful radio productions as "Flying Time," "Cameos of New Orleans," "Your Health," "Medicine in the News" and last year's "Doctors at Work." The scripts will again be produced by J. Clinton Stanley and the National Broadcasting Company orchestra will be under the direction of Joseph Ballichio as heretofore. Actors will be drawn from the well-known group of Chicago radio actors previously heard in American Medical Association and other successful broadcasts.

OBITUARY

JOHN T. FARRELL, M.D.

Dr. John Thompson Farrell, long a practising physician in this city, died October 13, 1941 at his home, Providence street, West Warwick, after a brief illness.

He was born in Webster, Mass., September 11, 1858, the oldest of five sons of the late Thomas L. and Catherine (Thompson) Farrell.

He received his medical degree from Jefferson Medical School, Philadelphia, in 1886, and later did postgraduate work in dermatology and roentgeneology in Paris, Leipzig and Vienna, as well as at Harvard Medical School and the Boston City Hospital.

He organized the department of dermatology at St. Joseph's Hospital in 1906, and was dermatologist and radiologist there until 1923. He was also physician at St. Vincent de Paul Infant Asylum and St. Aloysius Home, and a member of the consulting staff of the Charles V. Chapin Hospital.

Dr. Farrell volunteered for service abroad during the World War, but on account of his age was named a member of the Volunteer Medical Service Corps.

He was a charter member of the New England Roentgen Ray Society and a former President of that Society. He was also a member of the American Medical Association, the Rhode Island Medical Society, and the Providence Medical Association, serving as President of the latter organization in 1913-1914.

He was a member of the Providence School Committee from 1902 to 1905.

He is survived by his wife, Mrs. Annie Goffe Peckham Farrell, formerly of Newport; three sons, Dr. John T. Farrell, Jr., of Philadelphia, Allan Farrell of Philadelphia, and Donald Farrell of West Warwick, and two daughters, Helen H. and Alice G. Farrell.

ROLAND HAMMOND, M.D.
ROSWELL S. WILCOX, M.D.

DR. O. FLETCHER BEST

Dr. O. Fletcher Best was born March 5, 1862, at Grafton, Nova Scotia. He was a graduate of Provincial Normal School in Nova Scotia and taught school in various places in Nova Scotia before taking up the study of medicine. He was a student of the Halifax Medical College, now known as the Dalhousie University, located in Halifax, Nova Scotia. From there he went to New York University Medical College from which he graduated in 1889.

He practised in Maine for several years. In 1900 he took up the study of diseases of the Eye, Ear, Nose and Throat at Knapps Memorial Hospital, New York City, becoming Resident Surgeon, and remaining there two years. He came to Providence, R. I., locating on Broad Street in 1902. He was a member of the A. M. A. and the Rhode Island Medical Association. He was a 32nd Degree Mason and a Rhode Island Chapter of Shriners Member, also.

During his early career as a specialist he had the privilege of showing Helen Keller and the late Alexander Graham Bell around his birthplace, Nova Scotia.

In 1887, Dr. Best married Bella L. Rockwell of Wolfville, Nova Scotia. One child, a daughter, was born to them, Gladys Payson Best, now Mrs. William B. Bailey. Dr. Best also leaves two grandchildren who live in Yarmouth, Nova Scotia, two

brothers, C. Woodworth Best of South Dakota, and Dr. Herbert H. Best of Pembroke, Maine, a sister, Mrs. Grant Foote of Grafton, Nova Scotia, and a nephew, Dr. Charles Best, professor of physiology, Toronto University, Canada, and co-discoverer of insulin with the late Sir Frederick Banting.

Dr. Best retired from active practice less than a ago. He had a winter home in Orlando, Florida, where he died August 3, 1941. Cause of death attributed to coronary disease.

EDWIN G. THOMPSON, M.D.
N. DARRELL HARVEY, M.D.

RECENT BOOKS

THE 1941 YEAR BOOK OF GENERAL MEDICINE. Edited by George F. Dick, M.D., J. Burns Amberson, Jr., M.D., George A. Minot, M.D., S.D., F.R.C.P. (Edinburgh and London), William B. Castle, M.D., A.M., (Hon.) Utrect, William B. Stroud, M.D and George B. Eusterman, M.D., pp 848, with 176 illustrations, some in color, and many charts. Cloth, $3.00. The Year Book Publishers, Inc., 304 South Dearborn Street, Chicago, 1941.

The forty-first Year Book of General Medicine presents the outstanding developments of the year. In infectious Diseases, a new rapid diagnostic method for virulence of the diphtheria bacillus, new data on intravenous vaccination against smallpox, new skin test for susceptibility to pertussis.

In Diseases of the Chest, first report of successful treatment of chronic bronchitis with vitamin B_1, dosage of cod liver oil and tomato juice in prophylaxis of intestinal tuberculosis, inhalation treatment of asthma, sulfadiazine treatment of pneumonia. In Diseases of the Blood, beef albumin as plasma substitute for transfusion, isinglass as transfusion fluid in hemorrhage, detection of infectious mononucleosis. In Diseases of the Heart, a symposium on coronary thrombosis.

The book is crowded with practical material of the greatest value to the busy practitioner.

TECHNIQUE OF CONTRACEPTIVE CONTROL. By Robert Latou Dickinson, M.D. and Woodbridge Edwards Morris, M.D., pp. 56, paper 50 cents, The Williams and Wilkins Company, Baltimore, 1941.

A practical manual issued by the Birth Control Federation of America, Inc. With a foreword by Nicholas J. Eastman, M.D., Obstetrician-in-Chief, Johns Hopkins Hospital, and a Note of Introduction by Richard N. Pierson, M.D., President of the Birth Control Federation of America, Inc. The work is distinguished by its 50 illustrations taken for the most part from Dr. Dickinson's monumental work, "Human Sex Anatomy."

HANDBOOK OF COMMUNICABLE DISEASES. By Franklin H. Top, A.B., M.D., M.P.H. pp. 682, with 73 text illustrations and 10 color plates. Cloth, $7.50, The C. V. Mosby Company, St. Louis, 1941.

In this encyclopedic volume, C. H. Binford, M.D., writes on Leprosy, Patience L. Clarke, R.N. on Nursing Care, Bruce H. Douglas, A.B., M.D. on Tuberculosis, Gordon B. Myers, A.B., M.D. on Pneumococcic Pneumonia, Laura E. Peck, R.N. on Communicable Diseases in the Home, George Sewell, M.D., F.A.C.S. on Gonorrhoea, and Loren W. Shaffer, B.S., M.D. on Syphilis, Chancroid and Lymphogranuloma venereum.

The communicable diseases have been classified by common portal of entry, a method which is different but which it is hoped will be helpful to the student. The importance of correct diagnosis is stressed throughout the work. Thirty-three charts in the appendix compare the initial with the final diagnosis of the cases admitted to the Herman Kiefer Hospital at Detroit from 1927 to 1936. A complete bibliography is broken down as references at the end of each chapter. Illustrations are notable for their excellence. This is a work of great value to the student, pediatrician, general practitioner and public health worker.

THE TREATMENT OF INFANTILE PARALYSIS IN THE ACUTE STAGE. By Sister Elizabeth Kenny of Australia. pp. 285, with 70 illustrations, Cloth, $3.50, Bruce Publishing Company, Minneapolis and St. Paul, 1941.

The success of Sister Kenny's method of treating infantile paralysis has attracted the attention of medical men throughout the world. During the past two years she has demonstrated her work at the University of Minnesota Hospital and the General Hospital of Minneapolis, proving conclusively to prominent medical men that her method produces remarkable results.

The Kenny system avoids immobilization and treats symptoms as they arise during the acute stage. It aims at maintenance of the healthy condition of all tissues of the body, affected parts as well as unaffected both somatic and visceral, and reestablishment of normal nerve conduction paths and normal function of the affected parts.

A large part of the present book is given over to criticism of the orthodox methods of treatment.

The Kenney treatment has now been in use at the Minneapolis General Hospital for more than a year. On December 4 the National Foundation for Infantile Paralysis, at the annual meeting held in New York City, indorsed the treatment, and on the following day issued a statement urging the widespread use of the Kenny technique and suggesting that State and city health departments take steps toward training personnel in this system, which includes hot packs and delicate muscle manipulation rather than the use of the traditional splints.

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THIS IS WHAT S-M-A IS . .

A scientifically prepared formula for infants deprived of breast milk.

THIS IS HOW IT IS PREPARED . . . . . .

1. Empty one tightly packed measuring cup of S-M-A Powder into bottle.

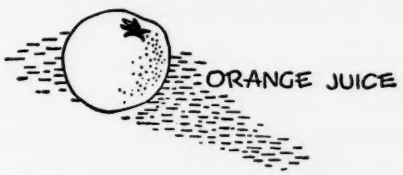
2. Add enough warm, previously boiled water to make one ounce.

3. Cap bottle and shake into solution. Feed at body temperature.

THIS IS THE WAY IT IS FED

The quantity and number of feedings in 24 hours should be the same as that taken by the normal breast-fed infant.

THIS IS THE ONLY SUPPLEMENT REQUIRED . .



AND THIS (in a nutshell) is the Easy, Economical Way used by an ever-increasing number of physicians to insure excellent nutritional results.

S.M.A. CORPORATION • 8100 McCORMICK BOULEVARD • CHICAGO, ILLINOIS

a natural source of

VITAMIN B_1

VITAMIN G

and other known factors of the

VITAMIN B COMPLEX

including nicotinic acid

MEAD'S BREWERS YEAST TABLETS • Each Mead's Brewers Yeast Tablet contains 20 International units of vitamin B_1 (thiamin—the antineuritic factor) and 20 Sherman units of vitamin G (riboflavin). Clinical tests have shown the product to be rich also in nicotinic acid, for the prevention and treatment of pellagra. Supplied in 6-grain tablets in bottles of 250 and 1,000.

MEAD'S BREWERS YEAST POWDER • Each gram (½ teaspoon) supplies 50 International units of vitamin B_1 and 50 Sherman units of vitamin G (the same potency as Mead's Brewers Yeast Tablets), as well as nicotinic acid. Mixes readily with various vehicles the physician may specify in infant feeding. Supplied in 6-oz. bottles.

Mead's Brewers Yeast is nonviable and is vacuum-packed to prevent oxidation. Packed in brown bottles and sealed cartons for greater protection.